

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07273

07286

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>16 Mns.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Island Creek</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>R</u> Last <u>Belt</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-7-1865</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A. (Md.)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Charles Belt</u>				14. MOTHER'S MAIDEN NAME <u>Antoinette Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Charles Belt Island Creek, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct. 1955</u> to <u>July 24, 1957</u> , that I last saw the deceased alive on <u>7/24</u> 19 <u>57</u> , and that death occurred at <u>12:50</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merle L. Gibson, Jr.</u> M.D. <u>Prince Frederick</u>				ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>7/24/57</u>			
PHYSICIAN'S NAME (Type) <u>Merle L. Gibson, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem</u>		22d. LOCATION (City, town, or county) <u>Pt. Republic, Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Q. Harkness & Son - Mutual, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>H. W. Ward</u> DATE <u>7-27-57</u>		24b. REGISTRAR'S SIGNATURE _____	

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*
 2. Sex: *Male*
 3. Age: *45*
 4. Date of death: *July 21, 1957*
 5. Place of death: *Home*
 6. Cause of death: *Heart disease*
 7. Physician: *Dr. J. Smith*
 8. Burial place: *St. Mary's Cemetery*
 9. Burial date: *July 23, 1957*
 10. Burial place: *St. Mary's Cemetery*
 11. Signature of physician: *[Signature]*
 12. Signature of registrar: *[Signature]*

BUREAU V. S.

JUL 31 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07274

(7287

CERTIFICATE OF DEATH

Reg. Dist. No.

57

1. PLACE OF DEATH a. COUNTY <u>Calvert County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Sunderland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Calvert County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jarah Grace</u> Middle <u>Smith</u> Last <u>Cottee</u>		4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30th</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Holland</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>William Cottee</u>		Address <u>Sunderland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V.R. disease</u> <u>443X</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u>7-26</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>George Weems</u> M.D.			
PHYSICIAN'S NAME (Type) <u>George Weems, Md.</u> <u>Huntingtown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>7-30-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Edmonds</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. F. Sewell</u>		24a. REC'D BY REGISTRAR DATE <u>7-29-57</u>	
ADDRESS <u>Prince Frederick, Md</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MA

RECEIVED
 JUL 31 1957
 BUREAU V. 2

<p>1. Name of deceased: <i>John Doe</i></p>	
<p>2. Date of death: <i>July 28, 1957</i></p>	
<p>3. Place of death: <i>Home</i></p>	
<p>4. Cause of death: <i>Heart Disease</i></p>	
<p>5. Signature of physician: <i>[Signature]</i></p>	
<p>6. Signature of registrar: <i>[Signature]</i></p>	
<p>7. Date of registration: <i>July 31, 1957</i></p>	
<p>8. Registrar's office: <i>Bureau V. 2</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

07288

Item 14 Film G218 7-31-57 et

CERTIFICATE OF DEATH

07275

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>N.J.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belmont</u>				c. LENGTH OF STAY IN 1b <u>16 x 22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>3226 Maywood Ter</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Wm</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/9/198</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo W Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Storia Ward</u> Address <u>620 Mchm St SE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>577-07-6449</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was fishing and fell on board, hit his head</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was swung to water and pulled in boat</u>			
20c. TIME OF INJURY Month, Day, Year <u>9</u> Hour <u>7</u> p.m. <u>18</u> <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Belmont</u> (County) <u>Cabot</u> (State) <u>MD</u>							
21. I certify that I attended the deceased from <u>9 P</u> , 19 <u>57</u> , to <u>9 P</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9 P</u> , 19 <u>57</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.				DATE SIGNED <u>7/18/57</u>			
PHYSICIAN'S NAME (Type) <u>H. W. WARD OWINGS, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chambers F. Home</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Harkness</u> ADDRESS <u>2221 - Mutual, Md.</u>				24a. REC'D BY REGISTRAR <u>H. W. Ward</u> DATE <u>7-19-57</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

JUL 23 1951

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The following copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07276

07283

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Blunkirk</u>				TOWN <u>Dunkirk md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				1			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles</u> <u>Franklin</u>				<u>7</u> <u>6</u> <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, (WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>m</u>	<u>C</u>		<u>Feb 15</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Farmer</u>					<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Daniel Franklin</u>				<u>Annie Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Oliver Franklin Dunkirk md</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.				16. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Cardio vascular renal disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Age</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/3</u> , 19 <u>57</u> , to <u>7/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/3/57</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>H W Ward</u>				ADDRESS (Street, city, town, state) <u>Owings md</u>		DATE SIGNED <u>7/6/57</u>	
M.D.							
23. (BURIAL, CREMATION, REMOVAL) (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>7-9-57</u>		<u>Coopers</u>		<u>Calvert Co. md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-8-57</u>		<u>H. W. Ward</u>		<u>P. I. Sowell Prince Frederick</u>			

CERTIFICATE OF DEATH

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RECEIVED

BUREAU V. S.

JUL 10 1957

RECEIVED

2-8-57 W. W. Ward

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Cabot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>Ches. Beach</i> <i>xo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabot Co. Hospital</i>		d. STREET ADDRESS <i>Md</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Carlton</i> Middle <i>Hallock</i> Last <i>Hallock</i>		4. DATE OF DEATH Month <i>7</i> Day <i>14</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/22/99</i>
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months <i>14</i> Days <i>14</i> Hours <i>19</i> Min. <i>57</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bus</i>	
11. BIRTHPLACE (State or foreign country) <i>Conn</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>L. B. Hallock</i>		14. MOTHER'S MAIDEN NAME <i>Lillian Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Nbr- Chy, Ches Beach Md</i>	
17. INFORMANT <i>Mrs. Chy, Ches Beach Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock</i> <i>812x</i> DUE TO <i>Crushed L. Chest and with</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>fractures of left lower extremity</i> DUE TO (c) <i>Hit by auto in N. Beach Md</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <i>Hit by auto in N. Beach Md</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hit while walking across street</i>	
20c. TIME OF INJURY Month, Day, Year <i>8:35 7/13 57</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i>	20f. (City or town) (County) (State) <i>N. Beach Md Cabot Md</i>
21. I certify that I attended the deceased from <i>19</i> to <i>19</i> , that I last saw the deceased alive on <i>12</i> , and that death occurred at <i>1:17 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H.W. Ward</i>		DATE SIGNED <i>OW-mp Md</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-17-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.W. Lees Son</i>		ADDRESS <i>Wash. D.C.</i>	
24a. REC'D BY REGISTRAR <i>Dr. Hugh Hardy</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. Hugh Hardy</i>	
DATE <i>JUL 16 1957</i>			

CERTIFICATE OF DEATH

BUREAU V. 2.

JUL 16 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

072785

07291

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN TB <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>L</u> Last <u>Leizear</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-9-1896</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE DEPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. GAS LIGHT CO</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>Frank Leizear</u>			
14. MOTHER'S MAIDEN NAME <u>Mary O'Brien</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW #1</u>			
16. SOCIAL SECURITY NO. <u>578-09-1391</u>				17. INFORMANT <u>Bertha Leizear</u> Address <u>Huntingtown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 16</u> , 19 <u>57</u> , to <u>July 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 28</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. de Villca RREAL</u> M.D.				DATE SIGNED <u>July 28, 1957</u>			
PHYSICIAN'S NAME (Type) <u>R. de Villca RREAL - SILVER SPRING, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington County, Va.</u>				22e. REC'D BY REGISTRAR <u>31 1957</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Pumphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24. REGISTRAR'S SIGNATURE <u>H. H. Ward</u>			

RECEIVED

JUL 31 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07292

CERTIFICATE OF DEATH

Reg. Dist. No.

072751

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Va</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ches Beach</u>				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Colonial Beach Va</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Barkinson</u> Last <u>Barkinson</u>				4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14, 1901</u>	
9. AGE (In years and birthday) <u>56</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u>		11. BIRTHPLACE (State or foreign country) <u>Wd</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John H T Barkinson</u>				14. MOTHER'S MAIDEN NAME <u>Emma</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs Emma Barkinson</u> Address <u>Colonial Beach</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dropped dead on boat in Ches Bay</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 2 hrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>3</u> a. m. <u>7/28</u> 19 <u>57</u> p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Boat</u>				20f. (City or town) <u>Ches Beach</u> (County) <u>Calvert</u> (State) <u>Md</u>			
21. I certify that I attended the deceased from <u>31</u> 19 <u>57</u> to <u>31</u> 19 <u>57</u> , that I last saw the deceased alive on <u>31</u> 19 <u>57</u> , and that death occurred at <u>31</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H W Ward</u>				ADDRESS (Street, city or town, state) <u>Quincy Md</u>			
PHYSICIAN'S NAME (Type) <u>H W Ward</u>				DATE SIGNED <u>7/28/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland PK</u>		22d. LOCATION (City, town, or county) <u>Balto Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc.</u> ADDRESS <u>5305 Howard St</u>				24a. REC'D BY REGISTRAR <u>Chas Cox</u>		24b. REGISTRAR'S SIGNATURE <u>Chas Cox</u>	

JUL 30 1957

BUREAU V. T.

JUL 30 1957

RECEIVED

072805

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Calvert
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Blanesville

STREET ADDRESS (If rural give location)

4. DATE (Month) (Day) (Year)
OF DEATH 7 - 21 - 1957

9. AGE last birthday 80 yrs

IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Months	Days	Hours	Min.

12. CITIZEN OF WHAT COUNTRY?

Bogina Wilson

17. INFORMANT & ADDRESS

Thelma Johnson, Lusk, Wnd.

18. MEDICAL CERTIFICATION

IMMEDIATE CAUSE	(A)
ANTECEDENT CAUSE(S)	DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE	(B)
STATING <u>UNDERLYING CAUSE LAST.</u>	DUE TO
	(C)

Coronary Occlusion
Generalized antero-lateral

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

2)c. WHERE DID INJURY OCCUR? (City or town)	(County)	(State)
---	----------	---------

21d. TIME OF INJURY (Month) (Day)

ay)	(Year)	(Hour)	21c. INJURY OCCURRED	
			While	Not while
		M.	at work <input type="checkbox"/>	at work <input type="checkbox"/>

21. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 1950, to July 21, 1950; that I last saw the deceased alive on July 20, 1950, and that death occurred at 4 P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED _____

23. BURIAL/ CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE _____

7-22-57

H. W. Ward

P. E. Sawell. Prince Frederick Md

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1.55 10M

BUREAU V. S.

JUL 28 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

07294

07281

07294

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Balto</u> b. COUNTY <u>Wd</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>411 Lyndhurst St</u>			
c. LENGTH OF STAY IN 1b <u>10 days</u>				d. STREET ADDRESS <u>Balto Wd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Adeline P. Sigold</u> First Middle Last				4. DATE OF DEATH <u>7</u> Month <u>14</u> Day <u>1957</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30 1901</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>14</u>		IF UNDER 24 HRS Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Wd</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm Parks</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Crockett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-26-7272</u>			
17. INFORMANT <u>Mr. Helene Humphrey</u> Address <u>411 Lyndhurst St</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cornary disease</u> DUE TO <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Solomons</u> (County) <u>Calvert</u> (State) <u>Wd</u>							
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D. <u>Owings</u>				DATE SIGNED <u>7/14/57</u>			
PHYSICIAN'S NAME (Type) <u>H. W. WARD</u>				<u>OWINGS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Tarkenton & Son - Mutual, Inc.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>7-15-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

RECEIVED

JUL 13 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH o. COUNTY <i>Calvert</i> <i>West Beach</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Beach</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Beach</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Maryland</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Ethel</i> Last <i>Stallings</i>		4. DATE OF DEATH Month <i>July</i> Day <i>23</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 23, 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Hall</i>		14. MOTHER'S MAIDEN NAME <i>Ella Grierson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs J. P. Williams</i>		Address <i>Law Haven Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cornary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>(Sudden death)</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had coronary thrombosis weeks ago</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <i>July 18, 1957</i> and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R de Villalier</i> M.D.		ADDRESS (Street, city or town, State) <i>5 Shepherd</i>	
PHYSICIAN'S NAME (Type) <i>R de VILLALIER M.D. - St Leonard</i>		DATE SIGNED <i>7/23/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 25, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt Harmony</i>		22d. LOCATION (City, town, or county) (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm A Hutchins</i>		24a. REC'D BY REGISTRAR <i>Wm A Hutchins</i>	
ADDRESS <i>Wm A Hutchins</i>		24b. REGISTRAR'S SIGNATURE <i>Grace L. Hutchins</i>	
DATE <i>7/24/57</i>			

BUREAU V. S.

JUL 29 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabaret</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ohriet</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First <u>G. Thomas</u> Middle <u>G.</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 3, 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. UNDER 1 YEAR <u>9</u> Months <u>20</u> Days <u></u> Hours <u></u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OR BUSINESS OR INDUSTRY <u>Home</u>	
11c. BIRTHPLACE (State or foreign country) <u>Cabaret Co., Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George B. Lusby</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Pragg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Bernard Thomas - Ohriet, Ind</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Parkinson's Disease</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8-10 yrs.</u> <u>? yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>300.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 22</u> , 19 <u>57</u> , to <u>July 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 22</u> , 19 <u>57</u> , and that death occurred at <u>11:55 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Merle L. Gibson Jr.</u> M.D. <u>Prince Frederick, Md</u> <u>7-24-57</u> PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 25, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ohriet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ohriet - Cabaret Co. - Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness</u> ADDRESS <u>4501 - Mutual, Ind.</u>		24a. REC'D BY REGISTRAR <u>H. W. Ward</u> DATE <u>7-24-57</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

RECEIVED

JUL 25 1957

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07284
51

07297

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Prince Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Co. Hospital				d. STREET ADDRESS Prince Frederick			
3. NAME OF DECEASED (Type or print) First Ernest Middle J. Last Vargo				4. DATE OF DEATH Month July Day 8 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 8th, 1904	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min 52		IF UNDER 24 HRS. Months 52 Days 52 Hours 52 Min 52			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Pa.			
11. BIRTHPLACE (State or foreign country) Pa.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Michael J. Vargo				14. MOTHER'S MAIDEN NAME Rose Kiss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Richard E. Vargo (Son)				Address Accokeek, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with DUE TO cardiac arrest during general anesthesia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.,				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 7/9/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-11th-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sammons Bros.				24a. REC'D BY REGISTRAR 11 1957			
ADDRESS Washington, DC				24b. REGISTRAR'S SIGNATURE Angie Ward			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUL 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07298
CERTIFICATE OF DEATH

07285

Reg. Dist. No. 51

1. PLACE OF DEATH o. COUNTY CALVERT MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE N.Y. b. COUNTY LONG ISLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE BEACH				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EIMOUNT ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 178 CREST AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK J. VENTIMIGLIA				4. DATE OF DEATH Month Day Year JULY 31 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 19, 1919 37 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Ventimiglia				14. MOTHER'S MAIDEN NAME Josephine Trillo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW # 120-12-9082		17. INFORMANT Address IDENTIF. DRIVER LICENSE NY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNED DUE TO BOAT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FIRE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BOAT CAUGHT FIRE & JUMPED OVER BOARD							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) FOUND Afloat, Picked up by C.G. at 8 AM							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year 11:20 a.m. 7/28 1957		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CHESA BAY CHESA. Bch CALVERT Md		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H.W. Ward				DATE SIGNED 7/31/57			
PHYSICIAN'S NAME (Type) H. W. WARD D.M.E. OWINGS, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Long Island National Funeral Home N.Y.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. D. Hachmann & Sons Mutual, Inc.				24a. REC'D BY REGISTRAR DATE 8-1-57		24b. REGISTRAR'S SIGNATURE H.W. Ward	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07299

CERTIFICATE OF DEATH

Item 1 Filed 7/26/57 cap

07286

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Prince Fred.</u>				TOWN <u>Prince Fred.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				/			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Basil H. Williams</u>				<u>7</u> <u>17</u> <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, (WIDOWED) DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>m</u>	<u>C</u>		<u>Sept. 15,</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>laborer.</u>					<u>Maryland</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Annie Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
			<u>215-25-9014</u>		<u>Mami Brooks Prince Fred. Md</u>		
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
I <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
				/			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)			21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Never attended</u>, 19....., that I last saw the deceased alive on <u>July 14</u>, 19<u>57</u>, and that death occurred at <u>12:1 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Merle L. Gibson Jr.</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>7-21-57</u>		<u>St. Paul Episcopal</u>		<u>Prince Fred. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-19-57</u>		<u>H. W. Ward</u>		<u>P. E. Sewell, Prince Fred. Md</u>			

BUREAU A. S.

107 23 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07300

CERTIFICATE OF DEATH

07287

Reg. Dist. No.

57

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First Middle Last <u>M. WOODBURN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Files</u>				14. MOTHER'S MAIDEN NAME <u>Jane ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-7045</u>		17. INFORMANT <u>Preston Woodburn - Solomons, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cornary Artery Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 27, 1957</u> to <u>July 27, 1957</u> , that I last saw the deceased alive on <u>7/27</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Merle L. Gibson Jr.</u> M.D. <u>Prince Frederick Md.</u>				PHYSICIAN'S NAME (Type) <u>MERLE L. GIBSON</u> <u>PRINCE FREDERICK, MD.</u> <u>7/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 30, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Solomons Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Solomons - Cabret Co - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>7-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 31 1957

RECEIVED